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ABSTRACT

The document reports on a symposium, sponsored by UNESCO (United Nations Educational, Cultural and Scientific Organization), designed to develop strategies for improving educational, health, and social service to handicapped children and their families, particularly in developing nations. Section 1 is an overview of the background and organization of the symposium. Section 2 offers summaries of opening remarks and of the discussions of four topics: (1) identification, screening, assessment, and evaluation of young children; (2) programs for children and parents; (3) personnel training; and (4) the blending of medical, health care, education, and social services. Section 3 lists recommendations to UNESCO including that UNESCO incorporate an awareness of the problems of disabled children in all UNESCO work; that UNESCO make data banks, such as ERIC (Educational Resources Information Center), more available and accessible to developing countries; and that UNESCO identify networks which already exist and encourage them to expand their materials/ activities to include information about disabled children. A final section contains summaries of presentations from representatives of the following countries: Japan, Egypt, Ghana, Nigeria, United Kingdom, Uraguay, Jamaica, Camaroon, United States, Mexico, Pakistan, Denmark, and India. An agenda of the symposium and a profile of participants are appended. (SW)

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International Symposium on Services for Young Disabled Children, Their Parents, and Families

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Proceedings:

Discussions And Implications For Future Activities

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December, 1981

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PREFACE

The Symposium on Services for Young Disabled Children, their Parents and Families was convened because many countries recognized the urgency of providing assistance to this population. Although the incidence of handicaps throughout the world is most often cited as one in ten percent,[1] studies done by international organizations and private researchers have estimated the incidence range from seven percent to sixteen percent.[2] It is almost universally agreed that these percentages are much higher in rural and poor areas.[3] One study reports that about two thirds of the handicapped population lives in more than two million rural villages worldwide.

There were some basic assumptions that provided the foundation for this symposium. Recognizing the large numbers of people with handicaps, the symposium participants believe that medical, social and educational intervention at the earliest possible point in the child's life may prevent or minimize further complications caused by the condition and can equip the child with the skills to participate more actively in the community. Further, the participants believed that families are the key in a young child's growth and education and that by helping parents understand their child's limitations and strengths and by teaching them ways to help their child learn, any work with this population is likely to be more effective not only for the child but also for the family and community. In addition, the participants believed that there are programs to assist disabled children and families which can be adapted and implemented in many settings at a low cost. The participants came together to discuss these programs and how to encourage their acceptance in as many places as possible.

Countries with a variety of situations, resources, experience and institutional structures were represented at this seminar. In spite of the obvious differences, the representatives agreed that, based on their experience, certain needs are universal. They believed that when a country is planning to develop or expand services for young children, certain issues and ideas should at least be considered.

The resulting document should be seen as both a checklist of considerations in planning and developing services and a list of some techniques and resources which have been helpful, particularly in countries with limited funding for services. This report is not meant to give detailed instructions on implementing services for young disabled children. Rather, it is an initial guide for leaders as they develop services to meet the needs of young disabled children throughout the world. The participants expressed the belief that an expanded follow-up conference, perhaps under UNESCO sponsorship, would be helpful to develop more detailed material and recommendations.

[1] Mayor, Federico. "The Handicapped Tenth of Humanity." UNESCO Courier, January, 1981.

[2] Wall, W. D., "UNESCO and Special Education for Handicapped Children", Constructive Education for Special Groups: Handicapped and Deviant Children. London: Harrap and Paris: UNESCO, 1979.

[3] Action, Norman, "Disability and the Developing World." UNESCO Courier, January, 1981.

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INTRODUCTION

In recent years, many of the developing countries with membership in UNESCO have indicated an interest in early childhood education and the early detection of physical and mental disabilities among young children. The provision of support services to the parents and families of these children is an area of particular interest to these countries.

In response to this interest, and recognizing the need for a forum to exchange information and ideas among nations, the Special Education Programs and the National Institute of Handicapped Research of the U. S. Department of Education in cooperation with the United Nations Educational, Cultural and Scientific Organization (UNESCO), sponsored an International Symposium on Services for Young Disabled Children, their Parents and Families.

This symposium was designed to provide an arena for discussing existing services for young disabled children, their parents and families. The main purpose of the symposium was to develop strategies for improving educational, health and social services for this population, particularly in developing nations. In addition, the symposium was to enhance the exchange of information among UNESCO member nations about successful programs and practices in early education and early identification of disabilities. The symposium brought together individuals experienced in providing these services and those interested in initiating similar programs.

Finally, the symposium was to result in a final document that would 1) make recommendations to UNESCO regarding ways in which that organization could help to improve programs for young disabled children world-wide, and 2) include information about successful, inexpensive, practical methods and programs that can be replicated or adapted easily.

This document is organized into four sections.

Section I is an overview of the background and organization of the symposium.

Section II provides summaries of opening remarks and of the discussions on the four topics.

Section III lists the symposium recommendations to UNESCO.

Section IV includes summaries of the participants' formal presentations.

ORGANIZATION OF SYMPOSIUM

Section I

The International Symposium on Services for Young Disabled Children, their Parents and Families, was convened in Washington, D.C. on December 6 through 11, 1981. The specific objectives were:

- To develop strategies for improving education, health, and social services for disabled children, from birth through eight years, and their families, particularly in developing nations.

- To enhance the exchange of information among UNESCO member nations.

The symposium discussions included four major topics:

- Identification, Screening, Assessment and Evaluation of Young Children

- Programs for Children and Parents

- Personnel Training

- Blending Medical, Health Care, Education and Social Services

In addition there were presentations of two United States projects which have been replicated in developing countries. The projects were the Portage Project, Portage, Wisconsin and the Chapel Hill Outreach Project, Chapel Hill, North Carolina.

A complete symposium agenda is provided in Appendix A.

Fourteen participants were invited by the U.S. Department of Education, with recommendations from UNESCO, on the basis of their experience in providing services for young children with special needs, their expertise in working with disabled children, and their interest in initiating inexpensive practical programs in developing countries. Representatives were:

. Cameroon	Sister Cecil Cusson
. Denmark	Mr. I. Skov Jorgensen
. Egypt	Dr. Mohyi El Din Ahmed Hussein
. Ghana	Mr. David T. K. Aryee
. India	Mr. Harcharan Jit Singh
. Jamaica	Mrs. Joyce Brown
. Japan	Dr. Hideo Ogamo
. Mexico	Mrs. Isabel Farha
. Nigeria	Mrs. Ellen Caulcrick
. Pakistan	Mr. Mike Miles
. United Kingdom	Dr. Duncan Guthrie
. United States	Mr. George Jesien
. Uruguay	Mrs. Eloisa Garcia de Lorenzo

Profiles of the participants are included in Appendix B. In attendance were representatives from UNESCO, Special Education Programs, and the National Institute of Handicapped Research of the U. S. Department of Education. Also presenting were Mrs. Anne Sanford and Dr. John Turner of the University of North Carolina at Chapel Hill.

Mrs. Eloisa Garcia de Lorenzo of Uruguay was elected Chairperson of the the symposium. Dr. Duncan Guthrie of the United Kingdom and Mr. Mike Miles of Pakistan were elected Vice-Chairpersons. Mr. George Jesien of the United States was elected rapporteur.

During the conference, one day was spent visiting the National Children's Center, the Training and Infant Intervention Program at Howard University Hospital and the Kendall Demonstration Elementary School at Gallaudet College. The participants also had the opportunity to spend part of another day at the annual conference of the Handicapped Children's Early Education Program.

SYMPOSIUM PROCEEDINGS: DISCUSSIONS AND IMPLICATIONS FOR FUTURE ACTIVITIES

Section II

The Symposium opened with greetings from officials of the United States Government and UNESCO.

Mrs. Jean Tufts, Assistant Secretary, Office of Special Education and Rehabilitative Services, U. S. Department of Education, presided. In her opening remarks she spoke of the team approach of the United States government and its commitment to working with other countries in providing an international program for disabled children and adults. Mrs. Tufts indicated that the Symposium would provide an opportunity to learn together, to gain perspectives on educating young disabled children, to share innovations, and to discuss common problems and solutions.

Miss Lena Saleh, the UNESCO representative, provided guidance on symposium format procedures. She also discussed UNESCO's commitment to the improvement of services to the disabled children around the world, especially in developing countries.

Dr. Cecilia Frantz, Director Designate of the National Institute of Handicapped Research (NIHR), U. S. Department of Education, discussed the Institute's long range plan for research. In this plan, NIHR affirmed its belief that infancy is the period of life during which the greatest amount of learning is acquired in the shortest amount of time, and that this early learning is essential to the development of competence in childhood as well as independence and self-fulfillment in adulthood.

Ms. Shirley Jones, Deputy Director of Special Education Programs, U. S. Department of Education, expressed pleasure in the fact that the Symposium brought together persons from many nations who were involved in early education for disabled children. She was also pleased that Special Education Programs was part of the cooperative effort with the National Institute of Handicapped Research, the Office of Interagency Affairs and the State Department UNESCO desk in planning and conducting the symposium.

Dr. John Rodriguez, Deputy Under Secretary for Intergovernmental and Interagency Affairs, explained that the idea for the symposium was conceived a few years ago at a UNESCO conference. He welcomed the opportunity for a fruitful exchange and emphasized the need for working together in order to improve services for disabled persons around the world.

Prior to the last session, Mrs. Virginia Knauer, Special Assistant to the President of the United States, spoke to the participants. She reiterated the United States' commitment to meet the challenge of improving services for disabled persons and emphasized that federal agencies are working cooperatively with the private sector toward this common goal.

Dr. Thomas Behrens, Acting Director of the Division of Innovation and Development, Special Education Programs, discussed the kinds of training Special Education Programs are sponsoring for neurologists and pediatricians. He stressed that helping disabled children must not be the total responsibility of educators, rather it must be a shared effort among professions.

Mr. Harold O'Flaherty represented the Secretariat of the U. S. Federal Interagency Committee of the International Year of Disabled Persons. He remarked that during this year six hundred million people had the opportunity to convince their communities of their capacities, commitments and unmet needs. He pointed out that in the United States this year the private sector established partnerships in 1,859 communities, 270 businesses and 500 voluntary agencies, solely for the purpose of communicating these capacities, commitments and needs. In addition, 45 federal agencies participated in IYDP activities. Mr. O'Flaherty reminded Symposium participants that this year was only a beginning and that a commitment is needed to continue to improve the opportunities for disabled people.

The participants came prepared to discuss the four symposium topics: identification, screening, assessment, and evaluation; programs for children and parents; personnel training; and blending of medical, health care, education, and social services. This section addresses each of these topics separately. Each topic chapter first summarizes the discussion of concerns and constraints, and then presents an outline of goals and priorities, possible resources, and methods and procedures to be considered in initiating or expanding these services.

Topic I - Identification, Screening, Assessment and Evaluation of Children

During the discussion, the terms identification, screening, assessment, and evaluation were used interchangably to describe the processes used to find disabled children and to diagnose their disabilities. During this session, the participants discussed the identification of handicapping conditions and the related problems involved.

The participants agreed that intervention should begin as early as possible in order to achieve maximum positive and long-lasting results. Therefore, it is essential to identify children with special needs at birth or soon thereafter so that intervention can be provided as early as possible.

It was evident that despite the cultural differences among the nations present, most had experienced similar problems in identifying, screening, assessing, and evaluating young children. Some of these problems were:

- lack of awareness of a disability in the child
- cultural taboos
- lack of appropriate diagnostic/assessment instruments
- lack of trained personnel to assess and diagnose the problem
- lack of funds

The participants agreed that the process of identifying and working with children with special needs must include changes in attitudes which, in some countries, currently may encourage hiding and segregating disabled children. By their own attitudes and actions, professional leaders and workers can influence the attitudes of families and the general public and reduce the stigma associated with disabilities. In looking at attitudes, workers must first look at themselves and decide whether they are inadvertently perpetuating negative attitudes.

The participants believed that disabled persons are the responsibility of the community in which they live. This includes the extended family, neighbors and friends. These traditional lines of responsibility should be emphasized as a key factor in changing attitudes. Once family, neighbors, and friends accept a disability, initiating assessment and appropriate treatment is less difficult.

In some Latin American countries, the treatment of disabled children varies with social class. Members of the highest social class may conceal the child but provide for tutors and other assistance within the confines of the home. This is not usually the case in families of lower socio-economic status.

In Pakistan a study was done to locate children with special needs. Students were dispatched into special localities to conduct a door to door survey. While there continues to be a real stigma attached to having a handicapped child (many children are hidden), fifteen hundred children were found. The results of the study provided the government with names and addresses of children needing special services.

Due to the increase in education and training of professionals, many cultural taboos have been erased. This has helped make identification of disabled children easier. Jamaica has addressed this problem through continued public education programs. Seminars are held twice a year for professionals and for others working with children to increase awareness of handicapping conditions. In Nigeria social workers and educators have worked very hard to make the public aware of the problems of disabled children. In Ghana the public health nurses are used in the identification process. They visit neighborhoods to locate children who might need special services.

It was agreed that there is a need for upgrading training for those who may come in contact with children with special needs. It was also suggested that curricula for secondary students should include information relating to needs and characteristics of these children. These two measures would have positive effects on public attitudes and awareness.

A number of participants indicated the need for locally developed instruments to find and assess children with special needs who are not easily or obviously identifiable. They also pointed out that the visibility of developmental delays often increases as the society becomes more technologically oriented.

Since assessment needs and methods vary from country to country the participants proposed a list of criteria which they believed should be considered when choosing assessment instruments:

- The instrument should indicate levels of strengths and weaknesses in developmental areas
- The instrument should measure sequential skills from simple to complex, instead of statistical comparisons
- The instrument should provide a clear assessment picture, which both teacher and parent can understand
- The instrument should allow for environmental and cultural differences
- The instrument should lead directly to learning objectives

- The instrument should provide appropriate techniques for assessing the child's capacity
- The instrument should provide follow-up so family members can assist in the learning process
- The instrument should allow for continuous follow-up and mastery check to accurately measure progress.

The participants thought that identification and adaptation of existing instruments should be the first steps taken when establishing or improving an assessment program. They also felt that professionals and parents should work to motivate governmental policy makers to initiate studies of child development in their areas.

The presentations of Dr. Hussein on page 27 and Mrs. Sanford on page 59 explain how Egypt has carried out some of these assessment ideas. In addition, the presentation of Mr. George Jesien on page 48 gives an example of an assessment instrument that meets the above criteria.

Another common problem expressed by the participants was the lack of trained personnel available to identify children with special needs, especially in rural areas. Centralization of services in large urban areas appears to make this problem more severe. Two viable solutions were offered:

1. Use peripatetic personnel to disseminate information to social and education personnel, thereby producing a multiplication effect on information transfer.
2. Develop methods to improve the use of local personnel, local customs, and simple local materials for the screening of children.

This subject will be discussed further in Topic III.

The participants developed the following guidelines for countries that are interested in establishing or expanding programs to identify children with special needs.

Goals and Priorities

Based on their experiences, the participants recommended that countries develop goals and priorities, first taking into consideration the suggestions listed below.

- Study the patterns of child development that are specific to cultural and geographic areas
- Develop and/or adopt appropriate assessment instruments in order to identify deviations or handicapping conditions as early as possible
- Use criterion referenced instruments
- Make the public aware of the importance and availability of services to identify children with special needs
- Develop assessment procedures that are directly related to programming content and teaching

Resources

As a second step in developing programs, existing resources should be surveyed and needs identified. These resources might include:

- Families
- Other children
- Health workers, paramedical workers
- Traditional birth attendants
- Community and religious leaders
- Volunteers
- Family health centers, maternal and child health centers
- Community development centers
- Schools
- Mass media
- Existing instruments for identification, screening and assessment

Methods and Procedures

The third step is to identify actions that should be taken in order to implement the program. Some suggested actions are listed below.

- Upgrade training programs for persons working with children, to emphasize early identification of children with special needs
- Identify and obtain existing assessment instruments
- Adapt appropriate instruments to meet specific needs of the country
- Include in the secondary school curriculum information on the needs and characteristics of children with special needs
- Disseminate information on child development and the characteristics of children with special needs to teachers, nurses, expectant and potential mothers.
- Utilize the mass media to disseminate information on the importance of early identification and the availability of services
- Initiate studies at universities and research centers to determine local patterns of sequential development

Topic 2: Programs For Children And Parents

After a child has been identified as having a disability, an appropriate intervention or treatment program has to begin. The participants concurred that in order for intervention with young disabled children to be successful, there must be a high degree of parental involvement.

It was emphasized that successful intervention programs must have two characteristics:

- Parents must be helped to develop confidence in their abilities to cope with, care for, and teach their disabled children
- Parents must have information, resources, and a process for sharing experiences with other parents experiencing similar problems

In addition, the intervention program must be interdisciplinary, and professionals must communicate with and be supportive of parents. Programs must also always consider the cultural norms and traditions of the areas. The center at Kaele, Cameroon is based on these premises. See page 45 for more detailed information.

It is traditional in many countries for older children to care for younger children. The participants emphasized the need to consider these caregivers in planning rehabilitation programs for young disabled children. These older siblings are an often untapped resource in caring for disabled children. The CHILD-to-child program is an example use of this resource. Dr. Duncan Guthrie's presentation on page 39 explains how this can be achieved.

It was agreed that parent intervention programs should use procedures that can be adapted to existing lifestyles. They should also use locally available materials and personnel to the greatest extent possible. The potential for replication and adaptation needs to be considered in planning quality programs.

Programs that illustrate these principles were discussed by the participants. In Uruguay, the Parents' Resource Center has been developed by and for parents to deal with the needs they feel are most important. Libraries and support services have been established for parents. Cameroon has also instituted programs to make parents effective teachers.

The Portage Project, a homebased instruction program utilizing parents and trained paraprofessionals, has been replicated in Jamaica. This Early Stimulation Project has involved parents and has been replicated in five other Caribbean islands. The project operates at a relatively low cost and makes toys and materials from scraps.

In summary, the participants emphasized that by incorporating these elements into parent programs, there is a greater likelihood for the successful rehabilitation of more disabled young children.

The participants developed the following guidelines for countries that are interested in establishing or expanding programs for young disabled children and their parents.

Goals and Priorities

Based on their experiences, the participants recommended that countries develop goals and priorities, first taking into consideration those listed below.

- Provide at least minimum services for as many children as possible
- Provide special services within the ordinary service structure to the greatest possible extent
- Encourage the family to be the major rehabilitative unit
- Establish parent groups
- Provide services for severely disabled children
- Emphasize children's abilities rather than their disabilities/ limitations
- Provide barrier-free access to programs and buildings
- Avoid labeling children
- Use procedures that are appropriate for the lifestyle and culture of the area
- Use local personnel and locally available materials

Resources

As a second step in developing programs, resources should be surveyed and needs identified. These resources might include:

- Families
- Other children
- Village health workers, traditional medical and paramedical workers
- Community and religious leaders

- Teachers
- Volunteers
- Existing programs for children
- Existing services into which children's services could be incorporated, for example, integrated rural development programs/agriculture programs
- Family health centers, maternal/child clinics
- Community development centers
- Schools
- Mass media

Methods and Procedures

The third step is to identify actions that should be taken in order to implement the program. Some suggested actions are listed below.

- Motivate parents to work with their young children
- Encourage parents to work with and give support to other parents
- Improve the teaching skills of mothers and fathers
- Develop programs that will enhance parents' self-confidence in working with their disabled children
- Stress the importance of the role of the father in the child's development
- Motivate and instruct other children to teach and care for younger children with special needs
- Provide training to upgrade knowledge and skills of teachers
- Use low cost, locally made, culturally relevant materials
- Integrate disabled and non-disabled children in programs whenever possible
- Focus programs on the interaction between child and caregiver
- Provide social as well as educational services; take measures to assure that people know these services are available, and take steps to encourage and assist people to use them
- Motivate and influence national and international government policy-makers to initiate and upgrade service programs for young children with special needs and their families

Topic 3: Personnel Training

In order for identification programs and parent programs to work effectively, there must be enough qualified personnel to carry out these programs. The participants agreed that there has to be a systematic framework for training of personnel, both professionals and paraprofessionals. The scarcity of qualified personnel, some participants felt, was a greater hinderance to providing appropriate services than was the lack of financial resources. The focal point of the discussion was the degree of personnel training needed before programs are started.

One viewpoint stressed that local paraprofessional personnel must be used, that low cost programs must be available, and their quality improved. In this way there can be services available, even though financal resources are limited. The other viewpoint stressed that programs should not be opened until sufficient qualified personnel were available. They emphasized that quality programs are not expensive, but specialized training is important. Handicapped children should not be shortchanged because of unqualified personnel. Entry criteria for teachers in the field of special education should be very selective.

The participants believed the following facts regarding personnel training should be considered.

- Decentralized training programs are more effective in providing personnel in rural areas
- Appropriate supervision is one of the key factors in guaranteeing quality work from personnel
- There is a dilemma as to whether specialized training should come before or after practical experience in teaching
- There is a need to train staff in how to work with professionals in other fields and how to provide information and training to professionals in related fields about the importance and procedures of identification, assessment and treatment of children with special needs
- Training programs can be used to change policy or philosophical orientation
- Providing courses about special education in the normal teacher taining curriculum can provide information and skills to trainees that may later enable them to work with and accept a student with special needs

Some examples of personnel training programs were presented by the participants. In Mexico, the government has mandated that every teacher without a speciality take courses in working with disabled children. This is an effort to change attitudes towards disabled children and to counter the tendency to segregate children with special needs.

In Pakistan there is a great shortage of personnel. In Peshawar, to overcome this shortage, persons who are interested are trained right in the classrooom. Practical experience is stressed. Very little time is spent on theory. A great deal of time is spent on building the teacher's confidence and promoting creativity. New teachers, once they feel confident, can then train other teachers.

One of the most discussed points concerned training abroad. Most participants agreed that in many cases the skills and knowledge acquired abroad were not easily adapted to the situations in the person's home country. Often the person trained abroad does not want to return. Some steps to alleviate this problem were offered and are listed in the following guidelines.

The participants developed the following guidelines for countries that are interested in establishing or expanding programs to train personnel to work with young disabled children and their families.

Goals and Priorities

Based on their experiences, the participants recommended that countries develop goals and priorities, first taking into consideration the suggestions listed below.

- Employ an adequate number of quality personnel relative to the needs of the country
- Provide ongoing training of personnel to assure continued staff competence and skill development
- Develop training programs
    a) for different levels: preschool, primary, secondary, vocational
    b) in different categories: supervisory professional, para-professional, volunteers
    c) in different fields: medical, educational, social
- Enrich the training programs of all professionals, not just specialists, by providing instruction/experience in working with children with special needs
- Use and improve practical local training
- Develop effective training programs abroad
- Provide appropriate supervision and the support needed to ensure quality and continuity of services
- Use normal technical aid funds for special purposes

Resources

As a second step in developing programs, resources should be surveyed and needs identified. These resources might include:

- Parents
- People who have had experience working with children with special needs
- People interested in being trained to work with children
- Volunteers, especially those who have had experience with disabled persons
- Experts in the country
- Service programs in the country
- Training institutions in the country
- Training programs abroad

Methods and Procedures

The third step is to identify actions that should be taken in order to implement the program. Some suggested actions are listed below.

- Develop training programs
    a) general basic training, with supplementary instruction in disabilities and working with young children with special needs
    b) specialist training, focusing on disabilities and working with children with special needs
    c) on-the-job training
    d) inservice training
- Study and develop teacher training curricula appropriate for preservice (college) and inservice programs
- Orient training program towards the practical rather than the theoretical

- Train personnel to provide training
- Train personnel for research
- Concentrate on training generalists when manpower is limited
- Focus on inservice training, especially when the staff members are primarily generalists
- Establish appropriate programs when personnel is trained abroad by:

    a) developing close communication between sending and receiving organizations in order to develop an appropriate training program

    b) deciding how trained personnel will be used when they return and making these decisions clear to trainees and the training institution

    c) sending only those who have already had practical experience

    d) informing receiving universities of the particular professional needs, demands and limitations that will be placed on a returning graduate

- Motivate and influence national and international government policy-makers to initiate and upgrade programs to train personnel to work with young children with special needs

Topic 4: Blending Medical, Health Care, Education and Social Services

Once a child has been identified and his/her disability diagnosed, it is essential that there be coordination and cooperation among the professionals from the various service disciplines involved. These professionals and paraprofessionals might include medical doctors, nurses, social workers, educators, and community health aides.

Participants agreed that the coordination among service disciplines is the key factor in providing children with effective and comprehensive programs. Further, without this cooperation, benefits from any one service could be minimized or even negated. For example, the benefits of nutrition supplements could be undone by the absence of clean water, sanitation, or immunization.

Because a child frequently needs so many different services, parents may get confused or frustrated trying to work with many agencies. They may get conflicting advice. Uncoordinated services may unnecessarily duplicate or counteract each other's work. The coordination of services can bring about more effective and beneficial programs in these ways:

- By facilitating an exchange of information on individual cases, and providing a joint effort to help the child
- By facilitating a cross fertilization among disciplines, increasing the knowledge and understanding of professionals about the needs of, potentials for and methods of serving children with special needs
- By upgrading the quality of general services, because as one participant pointed out, the richer the general services are, the less need there is to expend limited resources on special programs.

Even though the importance of coordination was stressed, participants recognized a number of problems that hinder these efforts including professional jealousy, lack of information about other professions and lack of communication among agencies.

Below are some examples of coordinated, comprehensive service programs. India has established the Integrated Child Development Services. It began in 1975 in thirty-three provinces. At present there are 200 projects throughout the country. The aim is to provide integrated nutrition, immunization, and health education services.

A program of prenatal and neonatal health care is making an important contribution to early detection, intervention, and the general provision of comprehensive services in Denmark. A great emphasis is placed on schooling, and a close relationship has developed among the medical and educational fields.

Japan's Ministry of Health conducts systematic medical examinations of infants while the Ministry of Education conducts medical exams of school age children. There is a sharing of information so that both physical health and educational needs are promoted.

The participants developed the following guidelines for countries that are interested in establishing or expanding programs that will effectively blend medical care, health care, education and social services.

Goals and Priorities

Based on their experiences, the participants recommended that countries develop goals and priorities, first taking into consideration those listed below:

- Establish an integrated system of basic medical, health care, education and social services for children and their families
- Increase the visibility and priority of services for children with special needs
- Encourage the interdisciplinary training of personnel
- Utilize the safe practices of traditional healers and other local customs
- Foster cooperation among the various professional disciplines and between traditional healers and their counterparts trained in western methods
- Establish preventive measures including immunization, sanitation, nutrition, treatment strategies and educational elements

Resources

As a second step in developing programs, resources should be surveyed and needs identified. These resources might include:

- Parents and families
- Consumers
- Practitioners in all relevant fields, including students
- Newly established staff, such as courtyard workers, community health aides, peripatetic and itinerant workers
- Disabled adults

- Volunteers
- Staff of integrated health centers
- Available basic services
- Extensions of existing facilities and services
- Health centers, multiple use facilities
- Communities

Methods, Procedures, Actions

The third step is to identify actions that should be taken in order to implement the program. Some suggested actions are listed below.

- Involve administrators and policymakers of all relevant ministries, agencies and disciplines, emphasizing their responsibility to ensure that their particular services are as effective as possible
- Utilize and educate the mass media to change public attitudes towards disabled people
- Establish small pilot programs that demonstrate the blending of medical, health care, education and social services and design these programs carefully to minimize error and to achieve immediate positive impact
- Encourage existing medical, health care, education and social services to incorporate related components of other areas, e.g., a nutrition program to include educational and immunization components
- Work to change the attitudes of the disciplines towards each other and towards disabled children and their rights to services
- Establish a system of referral, collaboration and follow-up among disciplines and services for specific cases
- Encourage all disciplines to respect parents by including them in discussions and decisions about the needs and recommendations for their children
- Establish a system of record-keeping, so that a child's records can be readily available to the new service providers as necessary
- Establish a system for the accurate registration of all births

- Establish a service directory or a service information center that would know of all services available in given geographical areas and the types of children they serve

- Assist parents in utilizing all available services, e.g., assign case workers to coordinate all needed services for a child or have parents do it themselves through information centers

- Incorporate into the training curricula of all relevant professionals information and instruction about working with children with special needs and about the services available to these children through other disciplines

- Work to enact legislation that will protect the lives and rights of disabled children

RECOMMENDATIONS

Section III

The participants of the International Symposium on Services for Young Disabled Children, their Parents, and Families, submit the following recommendations to UNESCO:

- That UNESCO increase activities to promote educational programs for young disabled children and the prevention of disabling conditions, particularly in developing countries
- That UNESCO develop training materials, especially in the area of education and interdisciplinary approaches, in collaboration with other specialized international organizations
- That UNESCO incorporate an awareness of the problems of disabled children in all UNESCO work
- That UNESCO increase substantially the allocation of funds to the special education program, in view of the fact that its 1979 report states that 10-15% of the chidren throughout the world are disabled
- That UNESCO support and encourage the Non-Governmental Organizations in their work for disabled children
- That UNESCO identify training institutes that are particularly suited for training people from developing countries and assist in their activities in the area
- That UNESCO establish international or regional centers that will collect, distribute, and lend reference materials on assessment, curriculum and training
- That UNESCO make data banks, such as ERIC, more available and accessible to developing countries
- That UNESCO identify networks which already exist and encourage them to expand their materials/activities to include information about disabled children
- That UNESCO sponsor an international study to establish guidelines that will assist countries a) in choosing appropriate technical assistance and b) in judging the applicability of products and the utility of methodology in order to facilitate services
- That UNESCO promote services for young disabled children by encouraging a closer relationship among United Nations organizations, regional international organizations, and parent and professional organizations, e.g., Organization of American States, InterAmerican Children's Institute, Organization of African Unity, Rehabilitation International

- That UNESCO persuade nations to ratify the Florence Agreement to consider good toys as educational materials for disabled children, thereby making them duty free under the Florence Agreement

- That UNESCO promote the recommendations of this symposium body in its member states.

In addition it was resolved that:

- Members of this symposium work with their countries' National Commissions for UNESCO and delegations to UNESCO to urge them to take responsibility and an active interest in the recommendations of this symposium

SECTION IV: SUMMARY OF PRESENTATIONS

During the symposium, participants presented information about programs in their countries. The presentations of the participants have been summarized and edited for this document. The following are summaries of those presentations.

JAPAN

Dr. Hideo Ogamo provided the symposium with the following information about identifications, screening, assessment, and evaluation in his country. The enactment of the Child Welfare Law of 1947 and the Maternal and Child Health Law of 1965 has produced a consistent system to care for the health of mothers and children. The results have shown a steady decrease in maternal, fetal and infant death rates.

In accordance with the Maternal and Child Health Law, when a pregnancy is confirmed, a handbook explaining maternal and child health measures is given to the expectant mother. This handbook lists necessary health care measures from the beginning of pregnancy to the time of delivery and also includes the basics of child care.

Much effort is made in the municipalities to maintain the health of the mother and children. Maternal and Child Health Care Centers have been established, and, together with public health centers, hold health classes for single women, newly wed women, and mothers. When necessary, individuals from health centers visit those who are pregnant and mothers of premature and new born infants to offer assistance.

Genetic counseling, amniocentesis, neonatal intensive care units, and monitoring systems for congenital abnormalities are recent developments which should become a part of Japan's public health system. It is hoped that these developments will permit early diagnosis as well as help in the prevention of disabilities in children.

In accordance with provisions of the Maternal and Child Health Law, screening for prenatal problems is conducted at three months, seven months, and nine months. Medical examinations are given at these same intervals. These examinations are provided so that disabilities can be discovered early and efforts can begin to halt the progress of the disability.

The Ministry of Health and Welfare conducts these medical examinations of infants while the Ministry of Education conducts medical examinations from age six when compulsory education begins. This screening helps identify those children in need of special consideration and initiates a discussion of their educational needs as well. The consistent scheduling of screening provides a systematic means of promoting the children's education as well as their physical health.

Considering the importance of early discovery and early treatment for the physically and mentally disabled, several measures are being promoted. Child guidance centers have lowered the age of children with whom they will work. As of May, 1980, 161 child guidance centers had been established as frontline agencies in child welfare in the urban and rural prefectures, as well as in the cities designated as metropolitan areas. Recently, counseling concerning physical and mental disabilities comprises 47% of all consultations held by child guidance centers and is the most frequently requested service. In an attempt to consolidate diagnostic, treatment and counseling services a comprehensive center will be established for these services.

The major facilities for physically and mentally disabled children are hospital homes for crippled children, muscular dystrophy wards, institutions for blind children, institutions for deaf children, and institutions for the severely mentally and physically disabled.

Some disabled children are institutionalized and some commute to special centers. Those who are institutionalized have mental illness, are without families, or are from families who cannot adequately care for them. The degree of disability is also a factor in deciding whether a person is to be institutionalized.

Appropriate programs are designed to meet the unique needs of each disability. Special emphasis is put on teaching the skills the children will need to function in society.

EGYPT

Dr. Mohyi El Din Hussein provided the symposium with the following information. In Egypt with the the aid of the Minister of Special Affairs education and health assessment procedures have been established to provide services for those who suffer from various disabilities. A study conducted in Cairo City in 1967 revealed that the incidence of mental retardation was three percent, and on that basis it was estimated that in 1979 more than one million persons were affected by mental retardation. Egyptian authorities have given special attention to this problem and facilities have been selected or established to counteract the problem.

One of the objectives of the facilities is to provide services for mentally retarded children and their mothers, starting early in a child's life. In order to be effective the services must include sound psychological assessment. Therefore attention is given to the development of testing procedures in order to differentiate the various types of retardation as culturally vs. genetically determined.

New assessment trends can be summarized as follows:

- Construction of standarized instruments which will show strengths and weaknesses of children so their development of needs can be determined
- A shift in the focus on statistical comparison of the young disabled children with normal populations to one on the sequential development of a child's skills
- Provision of assessment to anyone in need of information regarding a child's development
- Utilization of a multi-media environment and regular activities for assisting the target children
- Development of learning objectives for each child
- Access to appropriate applicable techniques to help in the development of the child's potential
- Involvement of the child's family members in the learning process
- Continuous follow-up for readjustment and/or the establishment of new learning objectives

Using these points as criteria to judge the state of psychological testing in Egypt, it was clear that currently no one test is sufficient. Thus there was a need to develop other assessment tools. Therefore in cooperation with the University of North Carolina Technical Assistance team the Learning Accomplishment Profile (LAP), was translated into Arabic and adapted to the Egyptian culture. The next stage is to develop norms to measure the effectiveness of the Learning Accomplishment Profile as a diagnostic tool in Egypt.

GHANA

Mr. David Aryee provided the symposium with the following information on identification, screening, assessment and evaluation and on personnel preparation in his country. Some years ago many developing countries did not acknowledge a need to help disabled people. These people were disposed of and those who escaped were used as as clowns, jesters or farm hands. Much has changed in developing countries and there is currently an aim toward identification of babies born with abnormalities.

Ghana has a Resource and Assessment Center which strives toward early identification. However, this center can only be found in the capital, Accra. In this Center officers or teachers provide inservice training and operate a peripatetic teaching area. The peripatetic teachers work with various service agencies to identify persons with special needs and advise them of appropriate services. In addition, there are workshops held for persons in social welfare, health services, and teachers in special education.

There is another center which serves only deaf children. There is also a nursery department for children between the ages of two and four. These children are referred by medical officers, social welfare officers, teachers and peripatetic teachers.

Some simple materials used in Ghana to screen children for hearing impairments are:

- Milk tins, filled with different amounts of sand, to determine hearing abilities in high, middle and low frequency sounds
- Crumpled paper to screen hearing
- Hand made dolls to encourage language development

In Ghana there is a need for more centers and methods of assessment. Progress is being made in meeting these needs.

It was further explained that, as a signatory of the United Nations' Declaration of the Rights of the Child, Ghana is fulfilling its pledge by expanding and improving its educational institutions for personnel training. Ghana is seriously handicapped by limited money and qualified personnel. Of these limitations, it seems the second is the more crucial, for without an adequate supply of qualified personnel, no amount of money can produce either the expansion or the improvement that is so desired. A report on the education of the handicapped in Ghana stressed that same point: "By far the most urgent problem in connection with the education of

the handicapped children in Ghana, is the need to train sufficient teachers for the handicapped. Notwithstanding the large numbers of these children not in school, no further special schools should be opened until the necessary staff is trained." Acting upon this recommendation, in 1965 the government established a college specializing in deaf education.

Nearly ten years later, a department of training for teachers of visually handicapped children was opened in one of the teacher training colleges. The training of teachers of mentally retarded children is currently persued in overseas colleges and universities, especially in the United States. Physically disabled children are educated in regular schools, so there is no need to train personnel specifically for this population.

As is true with all children, the handicapped child's interpretation of the world is influenced to a large extent by his teachers. Ghana feels that it is, therefore, very important that the teacher of disabled children be a competent person with desirable qualities such as love, patience and sympathy but not at the expense of academic preparation. In addition, the teacher must be able to teach the handicapped child the skills needed to return to his or her community. In developing countries, this causes a dilemma in the selection of personnel for training as specialist teachers because, for economic reasons, there are thousands applying for jobs and training programs. For example, in 1979, nearly eight hundred teachers applied for the two year deaf education specialist program; the colleges had a maximum enrollment of eighty. The responsibility for the selection of personnel for training falls on the principals at the training colleges, assisted by an interview team of persons interested in handicapped people. Minimum academic qualifications are prescribed by the Ghana Education Service. Subject specialists, diplomates and university graduates are some times given preference. All applicants must pass an entrance examination in English, be interviewed, and submit confidential reports from former universities and employers.

The teacher training curriculum includes the education of the child as a whole being. In addition, all students do 18 weeks of practical work. This program is over a two year period. They also have to do a child study, special project or a dissertation.

All successful students are awarded a specified certificate and are upgraded in salary. Since its inception in 1965, the college at Mampa has trained nearly 180 specialist teachers of the deaf from Ghana, Nigeria, Sierra Leone, Swaziland and Kenya. Teachers are accepted from all English-speaking countries in Africa.

In addition to specialist teachers being trained in Ghana, other personnel such as speech therapists, braille mathematicians, audiologists, and teachers of mentally retarded children are pursuing advanced courses overseas.

One of the major problems Ghana faces in this area is the high rate at which very good, experienced teachers leave Ghana. This again leaves Ghana without enough qualified teachers. Another problem Ghana faces is personnel who have been trained overseas. They return with sophisticated ideas but are unable to adapt them to the conditions in Ghana. They become frustrated and leave.

NIGERIA

Mrs. Ellen Caulcrick provided the symposium with the following information about identification, screening, assessment, and evaluation in her country. Nigeria has a population of 75 million -- the largest concentration of black people on earth. Accepted projections indicate that one tenth of the population within a country is considered to be in need of special care treatment and mental health services because of disabling and handicapping conditions. Thus Nigeria probably has 7.5 million disabled persons.

Programs for disabled children were initiated by voluntary agencies in the mid-forties. Through the years the emphasis in Nigeria has moved towards the education of disabled children in primary and secondary schools. However, the government is aware of the importance of early identification, screening, assessment and evaluation of young children. The Nigerian national policy on education of 1977 says, "Children's screening will be attached to most hospitals for early identification of handicapped children and for corrective measures and medical care before and after they reach the age of primary school." The Minister of Health and local health authorities should maintain a register of children at risk, that is, those having prenatal and natal incidences leading to malformation and possible organic disorder or any delay in acquiring important sensory motor skills which would help to identify children likely to experience problems.

The Child Guidance Clinic was established in 1964. This clinic has multi-disciplinary programs, with the services of the federal school, the psychological unit, guidance and counseling services and a remedial/vocational unit. In this program, and before assessment takes place, the problems of malnutrition, physical ailment and cultural or social deprivation are eliminated. Children are given the opportunity to express their feeling in play therapy in water and sand and with different types of locally made toys.

With these exercises professionals have been able to get to the root of many problems, thus helping the child to work his way back to reality and enabling him to accept remedial education which will ultimately lead him back to a class-room setting. While there is currently only one child guidance clinic in Nigeria, the government has approved a plan that within four years clinics will be established in each of the 19 states in Nigeria.

Nigeria participated in a UNESCO study of early detection, prevention and education of disabled children. Recommendations were made to the Nigerian government as a result of the study. This study revealed that there is no structured program for children in Nigeria for the early detection of handicaps. There are some good health programs, covering maternal and child health services and school health services, which identified and refer children to various teaching hospitals. Nonavailability of special facilities and personnel for the early detection and treatment was a major problem repeatedly mentioned throughout the study. Screening of infants and children is offered in a few hospitals which emphasize child health.

A few programs offer educational intervention for handicapped children at the preschool level. The availability of these programs varies according to the needs of the community. Supporting services rendered to disabled children and their families at different centers and clinics in different states, though inadequate, are thought to be very essential. However, few specialists involved show competence and interest. Universal free primary education, introduced in September 1969, opened up new avenues for early detection of handicaps and immediate referrals through the registration of school aged children six years old. Lagos State has had a school health service for 30 years. Services in other states, however, are hampered by acute shortages of drugs, protein supplements, health aid equipment, transport and trained personnel.

As in some other countries, superstitions and taboos create a barrier between the handicapped people and the community. Previously cultural beliefs indicated that disabling conditions were caused by God, breaking laws, family sins, or witches and wizards. However, programs mounted by the Ministry of Health in a few states have provided information and education. The Federal Ministry of Education carries the overall responsibility for services to handicapped children. Workshops, seminars and conferences are provided for professionals and the general public. The mass media has been used to educate the public in both urban and the rural areas. Parents are actively involved but not very vocal in demands for services.

Training for traditional birth attendants and other auxillary health workers is needed to reduce manpower shortages especially in the rural areas. Trained local people will prove invaluable, especially in the Northern parts of Nigeria. The federal government is training teachers and other personnel involved in the education of handicapped children.

As a result of this study, the following recommendations were made to the Nigerian government:

1) Each local government should maintain up-to-date record of all births.

2) The medical officer of health in each local government area should be notified within a week of the child's birth and should transmit this information to the local home health visitor who will make the first contact with the newborn baby.

3) The Federal Ministry of Health and Social Welfare should jointly implement early identification and treatment of handicapped children.

4) Home health visitors should be given additional training in identifying defects affecting the development of the baby.

5) The pediatrics department should work in collaboration with the medical, and social service department in each teaching hospital, referring children with congenital cases promptly to the social workers for supportive and follow-up services.

6) For children with disabilities, education should start as early as possible without any minimum age limit. The Ministry of Health and Social Welfare should work jointly with the Ministry of Education to encourage, subsidize and provide programs and service.

7) A biannual, multi-professional assessment should be arranged by the Assessment and Treatment Center for all children who are known to be at risk. Appropriate referrals and placement should be recommended.

8) The Federal Minister of Education should establish a standard psycho-educational service program in each state of the federation to reach children, particularly school age, who may have developmental problems resulting in psychological and educational difficulties.

9) A fully equipped comprehensive school health service should be established in each state of the federation with emphasis on early detection and treatment of handicapped children.

10) The Federal Ministry of Health and Social Welfare should commission the psychology departments of the teaching colleges in each state to carry out free routine tests and to work with the Departments of Medical Social Work for genetic counseling to reduce the incidence of birth defects related to sickle cell anemia.

11) Rubella immunization should be provided for all pre-adolescent girls in the federation.

12) Special attention should be given to the research in the diagnosis of cerebal spinal meningitis, which is one of the most serious causes of deafness in Nigeria.

13) Financial support should be given to the National Institute of Ophthalmology.

14) The Nigerian government should support efforts to train traditional birth attendants.

15) Extensive research should also be conducted for early detection and treatment of brain damaged and mentally retarded children.

16) Efforts should be coordinated in all reknown societies from all the states of the federation to protest resistance to the early treatment of certain categories of handicapped children.

17) A joint effort should be made by African countries to produce drugs, aids, and equipment for the handicapped people in Africa, since some of these products are expensive and not always available to meet immediate needs.

18) The federal government should reinstate the program for one wholesome, highly subsidized meal a day for all school children, especially those who are handicapped.

19) The voluntary organizations should intensify their efforts in the education, support and involvement of the parents of handicapped children, taking into account the important roles of local leaders and headmen for nomadic groups.

20) Specialists in the field of special education should be encouraged to conduct research into specific areas relating to early detection and treatment of handicapped children.

21) Appeals should be made to all concerned to keep an up-to-date records and statistics of medical, educational and social services rendered to handicapped children.

22) Every means of local mass communication should be tapped to convey the message of the importance of early detection and intervention, including involving village heads, local chiefs, community leaders, and headmen of nomadic groups.

23) The Ministry of Education, Health and Social Welfare should strengthen training programs for personnel coming into contact with infants and children.

24) The National Advisory Council on Special Education should coordinate the efforts of all statutory services and voluntary organizations at the regional, state and local authority levels.

25) Pressure groups, especially the National Advisory Council on Special Education, should be strong and vocal enough to advocate in the legislature for the rights of handicapped children in Nigeria.

UNITED KINGDOM

Dr. Duncan Guthrie provided the symposium with the following information about programs for children and parents.

An informal group of child health experts and teachers, considering what might be done for the International Year of the Child (1979), developed a scheme which has now come to be known as CHILD-to-child. They realized that it is traditional in many countries for older children to care for younger children. They also realized that if the older child could be taught basic health education facts in in school, this child could pass good health practices on to the little ones he or she would be taking care of during out-of-school hours. The scheme was to include simple lessons such as oral hygiene (cleaning the teeth), environmental hygiene (cleaning up around the house to discourage vermin and snakes and to impede the breeding of mosquitoes or water snails), prevention of accidents in the home, and similar topics.

A series of leaflets, each one dealing with a single activity, was drafted with the help of experts from Third World countries and published by CHILD-to-child in London. These leaflets were translated into a number of languages and distributed to developing countries with the caution that they could and should be adopted, adapted or rejected, as was appropriate for the local situation and needs.

One of the most valuable activity sheets is one that deals with diarrhea, which, because of the dehydration it causes, is a very common cause of death in developing countries. The activity sheet first describes, in simple terms, the body's need for water, comparing it to a flower in a empty vase. It then explains that a child with diarrhea should be given a "special drink", a glass of water with a level teaspoon of sugar and a three finger pinch of salt, every time a stool is passed. This treatment can easily be prepared and administered by another child.

Also of particular interest is the Shakir Strip, a narrow band or bracelet of old x-ray film or other unstretchable material. This is marked at specified intervals, so that when put around the arm of a young child, it will measure the size of the arm and identify if the child is well-nourished, at-risk or undernourished. The strip can be made and the measurements marked off by the elder child who can then use it to teach the younger children.

The range of activities covered by CHILD-to-child is being increased continually. Activity sheets on attitudes towards handicapped children have recently been added to the program. Other new sheets deal with the identification of deaf children or children with poor vision, what to do when the younger child is ill, nutrition and the need to eat green vegetables. In preparation at this time are sheets on (a) the management of small children's stools by older siblings (small children's stools have been found to be very much more dangerous than adults'), (b) the construction and maintenance of a child-size latrine, (c) helping profoundly deaf children and (d) CHILD-to-child in agriculture.

This Symposium should include the prevention of disability as well as the care of those who are disabled. One of the things that is unfortunate is that polio is still prevalent in the Third World. The Expanded Programs of Immunization (EPI) of the World Health Organization (WHO) has set a target year of 1990 for every child in the world to be immunized. Since it was possible to eradicate smallpox, it is hoped poliomyelitis can be brought under control. It can only be done, however, with the help of volunteers and Non-Governmental Organizations (NGO's). However, there are not enough existing trained professional personnel in the Third World countries to achieve this goal. A substantial injection of willing assistance to the existing scanty medical and paramedical personnel is needed.

An international CHILD-to-child Symposium was held recently and one of its objectives was to discuss what assistance it could provide to disabled children. First, it was decided to produce a CHILD-to-child publication dealing with the unique needs of disabled children.

Secondly, it was agreed to look at the contribution CHILD-to-child could make in refugee camps. This program seems natural for such situations where children are likely to be separated from one or both parents and where older children will often find themselves responsible for their younger siblings and other children.

Thirdly, it was suggested that CHILD-to-child should consider how it might help street children, who are increasing in number in many countries of the world. They are likely to increase with the continuing drift of rural populations to the cities, the growth of shanty towns and the frequent break-up of family structures.

There is a strong need for greater cooperation at all levels, between education and primary health care. Cooperation should exist at the ministerial level, the village level and in the poorer areas of cities and towns. School teachers and health workers are concerned about the welfare of poor children, are in closest contact with them, and have an in-depth understanding of their problems. They are in the best position to help these children, especially if they are given the information and support of their supervisors and agencies.

One of the legacies of the International Year of Disabled Persons is that there should be a general awareness among health workers and teachers alike that the care of disabled children and the prevention of disability are largely in their hands. They can play a major part both in the reduction of the incidence of disability in their community and in a reduction of the actual handicaps suffered by the individual children who become disabled. These can be achieved through the community, through the family and, last but certainly not least, through the other children by means of CHILD-to-child.

URUGUAY

Mrs. Eliosa Garcia de Lorenzo provided the symposium with the following information on the Resource Center of Parents. The development of the Center was financed by Partners of the Americas and International Business Machines. The aim was to bring together parents of very young physically disabled or multiply handicapped children who were in need of services. These parents and children were located through an advertising campaign and by referrals from physical therapists and doctors.

The parents became involved in the Center and devoted much time to studying journals, lists of activities and equipment catalogs from around the world. Parents divided into groups and began writing to European and Latin American countries for information on working with handicapped children. This produced a reference library of materials for the center.

The Center also actively involved parents in obtaining the consultation of various specialists who had backgrounds in providing services for handicapped children. These specialists helped develop mini-courses for parents. This previously had not been done in Uruguay. The parents organized the courses, and invited the experts. Because of this, the courses were directed toward the immediate interests of the parents. For example, one of the courses was on techniques of feeding children with muscular problems or difficulties in swallowing. As a result of the mini courses, a question and answer booklet for parents was developed.

The Resource Center also involves brothers and sisters in independent activities. The Center was involved in the International Year of the Child and is conducting a survey of attitudes and awareness of the community and the problems of disabled children.

There is concern for the continuation of the Resource Center. There are few problems which have arisen:

- Of the twenty-two parents who were originally in the Center only ten are left;
- Many parents had difficulty finding places to leave their children while they were involved at the Center;
- The expert consultants who readily gave of their time at the onset now want remuneration.

Many of the problems cited are a direct result of the economy. The materials developed are good, and persons continually visit the Center with requests. However, because of financial constraints, the continuation of the original plan is in jeopardy.

JAMAICA

Mrs. Joyce Brown provided the symposium with the following information on the Early Stimulation Project in Kingston, Jamaica. The Early Stimulation Project serves disabled children from birth to six years old. Parents, families, and community workers are involved in implementing this program.

There are at least two serious misconceptions commonly held by professionals in health, education and social welfare services in developing countries. These have obstructed development of services to train and educate the young developmentally disabled children. These misconceptions are:

- Handicapped children grow into dependent and non-productive adults. Therefore developing countries should not waste precious resources in providing training for them.

- Training and education of handicapped children requires specialized people working in a multidisciplinary team in a highly equipped center, on a one-to-one basis. It is too costly.

These misconceptions add up to the conclusion that these programs are not cost-beneficial. If developmentally disabled children in the developing world are to receive any assistance at all, it is vital that low cost models be developed to reach all children.

One such model was started in Kingston in September 1975 to guide and supervise parents in becoming teachers of their own young handicapped children in their homes. This has significantly improved the rate of development of such children and has demonstrated that service can be provided at low cost by previously untrained community workers. The Early Stimulation Project is based on the Portage Project of Wisconsin, which is a precision teaching approach implemented in the home. Intervention is designed to determine the needs of the child, capture the imagination of the mother and get her involved in the teaching process, thus reinforcing the bonds of attachment between mother and child. The model has been modified to meet the needs of Jamaica.

Staffing the project is a director who is a medical doctor, a supervisor who is a nurse and youth corps workers who carry out the initial identification and screening. Additionally, there are child development aides assigned to specific geographic areas. There is a need for more trained child development aides. Sometimes aides from a government program are used. Women chosen for these jobs must be literate, must have a desire to work with handicapped children, must have a family of their own (so they will be more conversant about child-rearing practices), and must have some community involvement experience.

The program is as follows:

1. Children needing help are identified. They are usually recognized as being slow in their development by their mothers, families or friends. The mother will then consult a doctor or nurse. Slowness in walking, talking or general development are the most frequent early signs.

   Sometimes the child may be identified as having a problem by a doctor or nurse on a routine visit to a clinic. In other cases children have been in day nurseries or residential homes and have been identified as having a problem. When a delay is suspected, the Denver Developmental Screening Test (DDST) is administered.

2. If the child is found to have a significant delay in development on the DDST, further indepth assessment, including a full history and medical examination, is performed. Then a program of intervention and treatment is designed.

3. This stage is a combination of teaching, training and therapy, and is carried out on a weekly basis at home. The most important aspect is that the mother gets fully involved in the program and carries out the training herself at home in between weekly visits by the Child Development Aides.

4. Progress is viewed and evaluated. This means that in addition to weekly visits by the Clinical Development Aides, the mother and child come to the program from time to time, usually every three to six months, for re-assessment and testing. The program is revised if necessary.

   The Kingston project is supervised by a public health nurse, but it could be done by anyone who has the appropriate training or experience.

The parents get further support in two ways. First, all parents new to the project are required to attend an informal orientation seminar. Second, there is a very active parent association which gives parents additional opportunities to be involved in the project. A strong point of the program is that learning is taking place during the preschool years in the home, which is felt to be the best place for learning. It is important to note that the mother or a family member is the primary caretaker doing the teaching. Siblings are also involved. Because of this, it is hoped that these children will have better parenting skills. This project is very low cost and therefore more easily applied in developing countries.

CAMEROON

Sister Cecile Cusson reported on the development of the Family Rehabilitation Center at Kaele.

Kaele is located in the extreme northern portion of the Cameroon. This desert area is commonly referred to as the pre-sahel belt. Cameroon is a developing country and, as in all Third World countries, the many vicissitudes of the world's economy have their effect on domestic life. While the middle class is rapidly emerging, the greater part of the population does not follow. The small peasants of the plains and mountains have a subsistance living standard dependent upon the precarious rain season.

In the Cameroon, schooling is not obligatory. Programs in early childhood education do not exist. The sick and infirm persons who live in the villages were relegated to the back corners of the compound. There is supersititon that any handicapping condition would spread to all.

The family is very important in African life. Experience shows that the family unit is a component in the rehabilitation of handicapped people. The family has always had an empathy for the healthy as well as the unhealthy. For the normal child, inclusion into the family unit begins at the fetal stage. In the majority of the ethnic groups during the Cult of the Ancestors Ceremony the expectant mother receives not only unctions like the other members of the family but also an extra one on the abdomen, for the unborn child is already considered part of the family. Tribal rites make a clear distinction between a biological birth and the official or social birth. The latter takes place when the child is taken from the mother's hut, which represents the womb, and is introduced into the father's courtyard. At this moment the child travels from the hands of women to the hands of men. The family is patriarchial, therefore, the child will belong to the father's family. The acceptance of the newborn is celebrated by a varied number of initiation rites. The child is shown the different parts of the family compound. He is brought into the bush area where he or she will be expected, later on, to bring back herbs for the sauce, wood for the heating and cooking, and straw for the roof. The assignment of the tasks is according to the sex of the child.

An abnormal child cannot integrate himself into this society. From birth he is faced with this problem. Up until a few years ago, the birth of twins or a disabled child was looked upon as an error. They were not considered a human life but rather as a water spirit having penetrated the body of a woman while bathing. It therefore had to be returned to its own underworld. So, the child would be placed on a rock on the edge of a water hole to enable it to rejoin its true parents. Again, this would explain why until recent times there were few, if any, children handicapped from birth. Today, pressures from both the mother's and father's families are exerted on the couple of a handicapped child. It is the entire family group that reacts when a handicap manifests itself in the course of the child's growth.

Before the child is weaned, it spends its time on the back of the mother. During this period the handicap poses few problems. After weaning, a child normally seeks to discover the world, but for the disabled child the problem begins. It is by games or imitation of others that children of the same age initiate themselves into society in general. A little child who cannot stand alone or chase grasshoppers or mice like the others suffers enormously. This condition condemns him to staying on all fours on the ground, and he is sometimes even crushed by those with whom he plays.

Parents of handicapped children try many methods or treatments to correct a handicapping condition. The parents and their handicapped child often come to the center at Kaele seeking treatment and additional help. The most urgent need is to provide primary care for the child and encourage parents to play an active role in the whole process. Once parents are liberated from all taboos, they are quick to understand what is expected of them. At Kaele parents are taught the necessary fundamentals of child care as well as special treatments they must know in order to cope with their children's particular disabilities. They not only tolerate but also encourage safe traditional treatments, such as therapeutic baths with leaves and roots and warm mud baths.

The parents come to understand the normal functions of the bones and muscles by comparing their children's with their own and to those of the animals they hunt. They are taught how to make and adjust braces, calibers and other aids from available materials. They are shown how these aids work. They are taught how to exercise outside in order to take advantage of natural elements that the children will confront: pebbles on mountain slopes, sands on the plain, cement at the school house. The children are taught how to fall so they can do so without getting hurt, so they can get up without help and so that they can be independent. Once a child knows that he can progress, he is ready to return to the village. He can be part of the village.

Parent education is an essential part of this program. In the evening the parents are gathered and the activities of the day are discussed: progress is pointed out, discoveries emphasized, methods used to encourage children are recognized, harshness and lack of patience are pointed out. This time is also used to teach methods for cleanliness, nutrition, prevention, and first aid. Special work is done with pregnant mothers and attention is given to family education and social education. Private assistance is provided for the couple who is interested in spacing births or who may have problems in their sexual life.

The various stages of rehabilitation contribute to changes in attitudes among the parents. A parent's belief that their child can progress and be independent is the most essential ingredient to that child's independence. However, the main characters effecting the child's entry into the local society may be the child's peers and the villagers themselves. The parents must be prepared to help their child in this process, to help him maintain his dignity. The philosophy at Kaele is that of encouragement. The program is not performed by using specific skills, charts or assessment tools. Progress is made by encouraging an awareness of handicapping conditions and developing a group approach toward helping the handicapped prepare for the future.

UNITED STATES

Mr. George Jesien provided the Symposium with the following information about the Portage Project, a home based program for disabled children and their parents. The Porgage Project began in 1969, as one of the U. S. Office Office of Education's first models for serving young handicapped children birth to six years old in a rural area. Since then, the project has been adapted in a variety of cultural contexts in more than 140 sites in the United States and Canada, as well as in more than 20 other countries. The Portage Project materials have been translated into 12 languages.

The basic project model involve home teachers who visit each of twelve to fifteen families once a week for an hour and a half. During the home visits the teacher and parents worked on a variety of developmental activities which were then continued by the parent during the rest of the week.

Evaluation results showed that children made substantial and significant developmental gains in the acquisition of physical, cognitive, social, language and self help skills. Comparisons using a variety of assessment instruments such as the Stanford-Binet, the Bailey, the Alpern-Boll and the Cattel showed consistently greater gains of children receiving project services when compared against control children.

Due to the positive evaluation results and high parental satisfaction local school districts assumed the costs for the program when federal funding for direct services terminated in 1972. Also because of the positive evaluation results, the project received funding from the U. S. Office of Special Education to provide training and technical assistance to public school systems, private agencies, hospitals and other institutions that wanted to replicate the model. The project has expanded to serve two child populations: children with special needs and economically disadvantaged children.

All of the Portage Project programs work on the same basic assumptions:

1. Intervention should begin as early as possible.

2. The child's parents are the most significant factor in his or her development.

3. The most natural and effective environment for working with the child and his family is the home. The Project does not mean to insinuate that classroom based programs are ineffective, but rather to recognize the primary importance of the home.

4. A personalized, developmentally sequenced approach guides the Project's pedagogical activities and development of curricular activities. Each child's particular strengths and weaknesses have to be addressed in whatever programming is done.

5. Finally, the focus of intervention should be neither the child alone nor the parent alone, but on the interaction between child and parent.

The first step in the Portage Model is the identification and/or screening of children to determine their eligibility for the program. The Project has found that the greatest response is obtained from brochures and leaflets directed towards parents and left in markets, stores, dental offices and other places where adults congregate. Short radio messages have also been effective. Each message is designed to use language that parents understand and to avoid catagorical lables such as "mentally retarded" or "physically handicapped." The text is basically: "If you know of a child who may need help walking, talking, seeing or hearing, please contact us. We may be able to help."

The next procedure in the model is assessment. A formal standardized instrument and a series of informal procedures are used to assess the child. This assessment identifies the child's strengths and weaknesses as well as those environmental and teaching factors that are most conducive to his or her learning. The child's skill level is determined by using the checklist of the Portage Guide to Early Education. This identifies what the child already knows and what he or she is most likely to learn next. This information is used in developing an individualized education plan for the child.

The Portage Guide to Early Education has been found to be very effective in working with parents and their children. The staff has found that it can be easily used by teachers with a variety of backgrounds and can be easily adapted to different programs contexts and cultures.

The Guide consists of three parts: a manual, behavorial checklist and a card file. The manual describes the developmental areas covered by the curriculum: infant stimulation, cognition, language, motor development, socialization and self help. The manual also contains directions for planning and implementing educational activities. The checklist contains a list of developmental skills in the six areas of development for children birth to 6 years of old. This helps the teacher to identify the skills, behaviors and abilities that the child has already acquired and those that he is most ready to learn next. Though the checklist is not meant to be applied rigidly, earlier items are prerequisites for later skills listed later. All children will not follow the sequence exactly as shown in the checklist but its administration should provide a fairly accurate picture of a child's present ability level and provide a number of alternatives for the next steps to teach that child.

Each checklist item is supported by a corresponding card in the curriculum file. Each card contains three to six possible ways of teaching the skill mentioned. The intent is not to dictate procedures, but rather to offer alternatives from which the teacher may choose and to provide ideas which will stimulate the teacher's own ingenuity and creativity.

Once a child has been evaluated and educational goals have been selected, the actual work of teaching begins. The focus of this process is the natural teaching-learning interaction between child and parent in the home. The role of the home visitor is to facilitate this process. Because of this focus the home visitor serves as a preschool teacher as well as an adult educator. The teacher must show what and how to teach the child so that it will be meaningful to the parent.

The Project has a four step process to facilitate the parent and teacher working together:

- First, the home visitor demonstrates the activities selected for the coming week. During this demonstration the visitor determines whether it needs to be modified so that it is neither too easy nor too difficult for the child and the parent.

- The next step is to have the parent try the activity with the child. This step provides the parent with an opportunity to practice the activity and the home visitor a chance to see if the parent understood the information and how to carry out the activity. This is also a time used to give encouragement and praise to the parent on how well he or she is interacting with the child.

- The third step is a review of the activity during which the parent and the visitor discuss its purpose, when it could most naturally be done during the day and what household materials could be used to teach or enhance the activity.

- The final step actually occurs at the beginning of the subsequent visit. The home teacher reviews the previous week's activities to see if the goals have been reached. If not, she then discusses it with the parent and modifies the activity or changes the materials so that it will be easier for both parent and child to do the coming week. If the activity was successful, the teacher comments on how well parent and child are doing and proceeds to the coming week's activities and repeats the cycle.

The four steps are designed to address the learning needs of the parent. The demonstration provides a concrete example that is directly related to everyday activities. The parent's demonstration gives immediate feedback so that the probable success or failure of the activity can be determined immediately. The entire session provides a context for establishing a trusting relationship over a common interest, the optimal development of the family's children. The ongoing relationship of the teacher and the family and the accumulation of these concrete experiences improves the parents' self-concept as competent parents and effective teachers.

The model includes time for less structured activities in which all members of the family can participate. The informal activities help the child to generalized and maintain previously acquired skills. In addition, time is set aside to identify, define and discuss parental concerns. The teacher serves as a resource, providing assistance in developing a realistic action plan for the coming weeks. The goal is to provide parents with information and skills necessary to obtain those services that are available in their local.

From experience it is strongly recommended that weekly meetings be held where teachers can review the previous week, plan for the coming week and discuss any problems which have occurred. These half-day meetings provide opportunities for both planning and inservice training.

The model has been adapted and implemented in more than 20 countries, including American Samoa, the Dominican Republic, Ecuador, Japan, Malaysia, New Zealand, Peru and Venezuela. One of the developed projects is in Jamaica, which now serves as model for programs serving exceptional children in the other Caribbean countries. The success of the model and its materials in these countries depends on their adaptation to local cultural values and to children's and parents' needs.

These replication efforts have resulted in programs of varying sizes, serving children whose problems range from severe handicaps to insufficient stimuation for optimal development. The education and background of home visitors vary greatly from site to site and include nurses, other health workers and community women as well as professional and paraprofessional preschool teachers. The essential element of all these programs has been the adaptation of the model to the local context. Before replication, careful attention was given to factors such as: the type of personnel to be used, the population served, local child rearing practices, traditional values, family roles, community involvement in the planning and execution of program use in the home, incorporating objectives and activities from the Portage Guide to Early Education.

One such replication effort was a collaborative project with the Peruvian Ministry of Education. The purpose of the project was to modify the model's procedures and materials for use in urban and rural poverty areas, validate it within marginal areas in Peru and evaluate the results.

Of the three and a half million children in Peru under six years of age, only 500,000 of them receive some form of preschool services. The majority of the children not receiving services live in marginal areas characterized by high malnutrition and morbidity rates, scarcity of health facilities, high unemployment, low per capita income and a resultant lack of stimulation necessary for development.

The Project has been implemented on an experimental basis in two urban areas in Lima, and in four Andean bilingual communities near Cuzco. The program was carried out by home teachers who were non-professional women, selected by the

community and supervised by a professional initial education teacher. To facilitate the work of the non-professional personnel, project staff have adopted Peru's Initial Education Curriculum for use in the home, incorporating objectives and activities from the Portage Guide to Early Education.

Training efforts responded to the varied education and experience levels of program personnel. Professional initial education teachers, master teachers, and zonal and local supervisory staff were trained in an intensive one week session designed to provide them with a theoretical and practical base in the program. Non-professional home teachers received three weeks of training in child assessment procedures, curriculum planning, techniques of working with parents, and strategies for teaching children from two to five years of age. Included in the training was information about nutrition, health and hygiene as well as a workshop on making educational materials from objects commonly found in the homes and communities. A mini-training, held after the home teachers had been working for approximately two months, served to reinforce the previous training and address problems identified by the master teachers.

Another training component used in the program was weekly staff meetings where home teachers discussed common problems and successes. At these half day meetings, guests speakers gave additional information on topics such as dental care for available community resources. Master teachers gave additional help to the home teachers during their supervision visits. The home teachers were observed and given suggestions for additional materials, improvement of teaching techniques and methods of improving parent-child interaction.

The majority of the home teachers in Lima had some secondary education while those in the Cuzco programs had a partial or completed primary school education. Because of these educational differences, more basic aspects of program procedures were emphasized in Cuzco with many supervised practice sessions. Also, training was presented in both Quechua and Spanish due to the bilingualism of the rural area.

Actual program implementation involved home teachers visiting ten to fifteen families for one hour, weekly. Most of the visits took place in the home with the mother, but when this was not possible sometimes a grandmother or older brother or sister carried out the activities. If the mother had to help with planting and harvesting of crops, visits were often carried out in the fields. The intent of the program was not to burden the mother with additional responsibilities but rather to improve the quality of the interaction between parent and child in the time that was available.

With a master teacher, the home teacher chose weekly activities planned how she would teach the objectives. The home teacher then followed the basic home teaching model as described earlier. Because the majority of parents were not literate, especially in the rural programs, heavy emphasis was put on the demonstration and practice segments of the process. In the urban sites simple activity charts were used to monitor child progress and parent teaching. Though not necessary, these charts assisted in the ongoing planning of the programs.

Materials used to teach activities varied greatly between the rural and urban programs, but in both areas materials readily available in the home and community were used. The home teachers either made the materials beforehand in group working sessions or together with the mother during the home visit. Parents were also encouraged to make their own materials using models and suggestions given by the home teacher.

Project staff developed a training manual for professional and paraprofessional staff and a nutrition health and hygiene manual which were used in the preservice and inservice training components of the project.

The evaluation showed that community women with relatively low levels of education and little or no previous experience in working with children had a significant impact on the development of children. Children showed substantial gains in cognitive and perceptual motor functioning when compared with control children. Parents said they were satisfied with the program, felt that it had helped their children and highly recommended it to other families. Homes that received the home visitors were visibly different at the end of one year. Children's playthings, furniture, and productions such as drawings were much more evident.

Significant changes were also observed in the home teachers. Not only did their reading and writing skills improve, but they also gained self confidence. A cost analysis showed the program to be the same as or less expensive than already existing programs. Although future modifications will be needed, the Peruvian Ministry of Education has approved the program for use in Peru.

This and other experiences in replicating and adapting the Portage model in other countries have shown that intervention programs that directly involve parents in the education of their disabled children are feasible, cost efficient, and effective in stimulating child development and enhancing interaction of parent and child.

MEXICO

Mrs. Isabel Farha discussed a new program in Mexico to train teachers in special education. A few years ago the government of Mexico became more interested in serving more children and expanding services. In order to do this, more trained personnel were needed. After assessing the needs of the population, the Ministry decided to concentrate the training efforts in three specialty areas where there were shortages: speech and hearing, mental retardation, and learning disabilities.

Because education services must be provided to children with special needs from six to 14 years old, the Ministry of Education focused on upgrading the skills and specialized knowledge of its primary school teachers. They implemented this program in two stages. First, primary school teachers were given a short specialized program to introduce basic information about recognizing and teaching children with various types of special needs. Second, courses were opened to train teachers as specialists. The program was divided into three major components. Scholarized (academic) training included courses offered during the first summer. Non-scholarized training including reports, bibliographies, research and supervised work with children, was done during the school year. These first two components were required of teachers in all three specialities. The regular curriculum encompassed language development, cognition, neuro-psychology, didatics, pedagogy and other elements of teaching. The third component involved three more summers of classes directly related to specialty areas.

Two important philosophies are incorported throughout the program. In an effort to change attitudes towards disabled children and counter the tradition of segregation, the curriculum is infused with the concepts of normalization and integration and the idea of "a child is a child first" with the same needs as every child.

This system has not been problem free. Initially there was only one teacher training center which was located in Mexico City. This limited the number of teachers who could be trained and the amount of training they could receive. Two years ago a training center was opened in five Mexican states. All of the centers offer programs in all of the specialty areas. This allows teachers to enter the program without travelling far, to take courses in the summer and to more easily complete their special and supervised work during the school year. Although the teachers complain of too much work, an evaluation shows that teachers are more knowledgeable in their specialty areas and better prepared to work with disabled children. Under this system, 150 teachers are trained each year. The state centers have proved to be so economical and productive that they hope to open more.

All primary teachers who have not declared a specialty were required to participate in this program. The government is obligated to hire every person who completes this program, regardless of whether they are judged to be good teachers or not. Once hired, the person cannot be fired. This has inspired the programs and supervisors to make this training as intense and comprehensive as possible, resulting in more, better prepared teachers.

PAKISTAN

Mr. Mike Miles spoke about the personnel program in his country. Pakistan is a big country of 85 million people, increasing over three per cent per annum. Customs vary in different parts of the country.

In the Northwest Punjah province there are 15 to 20 million people including three million Afghan refugees. The infant mortality rate in this area is 100 to 150 per thousand. About 30 percent of the population is literate; 15 percent live in urban areas, and 85 percent in rural areas. There is a rigid separation of men and women, which means there must be two of everything, including single sex schools.

Some of the prominent needs in Pakistan are getting clean water piped into villages, making basic health services available, improving common health problems and nutrition, and providing basic appropriate schooling and vocational training. Therefore working with handicapped children is not top priority. The work that is being carried out now is the foundation for the future, when Pakistan has the finances to devote to the education of handicapped children. When Pakistan is ready for this they will have staff trained and teaching materials prepared that will give the country a basis from which to start.

There are major obstacles in the development of rehabilitation services in Pakistan. One is attitudes; the other is the shortage of personnel. While the first must be solved locally by the Pakistanis, the program in Peshawar can contribute to the solution of the second.

A teacher for a basic school in Pakistan receives one year's training which is primarily rote learning and memorization. There is no formal training available for teachers of mentally retarded, blind or physically handicapped children, although there is some training for teachers of deaf children. The Peshawar school provides on-the-job training for teachers of disabled children; very little time is spent on theory. The first part of the training is learning what to do and how to do it. The second part is fostering the confidence to do it. This second part does not usually enter into training schedules, but emphasizes promoting creativity and building confidence and putting into practice what is known as the most essential ingredient of training. Once this is accomplished, the new teachers can train others. To be accepted as a trainee a person must enjoy children and must be able to read. There are currently 40-45 children and 15 staff members at the Peshawar school.

Today there is another school which was opened by the teachers trained in Peshawar. There is another in Mardan, and two more planned. The new schools are started with the support of parents and other local professionals such as psychologists and pediatricians, and staffed by teachers who have spent three to four months training at the Peshawar school. These teachers are always free to return for help, additional training and support.

A plan has recently developed with UNICEF to formalize the system that has been used for the last two years. Concentrating on towns with populations of 50,000 or more and following up on the survey mentioned earlier in the conference, two people will work on the frontier (the Northwest Punjah province) to find parents who are interested and are willing to develop services for their disabed children. They also will find people who are willing to build parent-professional associations. Once established, the association can send a local person to Peshawar. After three to four months of training this person will return with a teacher from the Peshawar school who will stay for two to three months to help build the new program. These new programs will be built around local priorities and can take on any form from building needed equipment to opening a specialized school.

Also included in this UNICEF project will be subsidiary projects: revising the child development charts, developing parent counseling materials and writing do-it-yourself guidelines on how to start a school. Sometime in the future, when there are schools and services throughout the province, it is hoped that there will be trainers traveling and offering short refresher courses as well as longer courses offered at a summer school.

The training at Peshawar is a middle ground between the lengthy, sophisticated overseas training the Pakistani government offers and the one week training with manuals the World Health Organization offers. The Peshawar school offers short term, on-the-job training with continued support and additional training afterwards.

UNITED STATES

Mrs. Anne Sanford provided the symposium with the following information about the Learning Accomplishment Profile.

The Learning Accomplishment Profile (LAP) was developed by the Chapel Hill Outreach Project, in Chapel Hill, North Carolina. It has been adapted to Head Start Programs, rural programs, and programs in other countries such as Egypt, Israel, Guam, Australia, and parts of South America. The LAP is suitable for use by paraprofessionals, as it is specific, easy to administer, and reliable. The LAP is a developmental assessment instrument which crosses all types of disabilities, and looks at children as children. It includes cognitive, language and six other areas of development. Included also is an instrument designed for infants or children who are functioning in a zero to three year old developmental range.

In the last decade, developmental theorists and educators have stressed the importance of the first three years of life in a child's long term development. It has been found that the beginning dictates the outcome and, for the child who develops problems prenatally or in infancy, it is imperative that diagnosis be made and treatment begun as soon as possible.

Because of the nature of some pregnancies, unusual health problems or family history, some infants are considered high risk candidates for developmental problems. For these children, early intervention with sensory stimulation can help overcome early deficits. Without these early supplementary services, at risk infants may suffer further developmental delay extending into the child's school years and on through life.

Some children display obvious handicaps at birth and for them early stimulation is critical. Severe physical and mental adnormalities which are evident in infancy demand immediate professional attention and may require years of intervention services. Research indicates, however, that the earlier the professional treatment occurs the more significant and successful will be the impact for optimal long term development. As research continues to emphasize the need for early intervention for children with developmental problems, current legislation and efforts by various advocacy groups has stimulated the creation of more programs for handicapped infants and their families. With this increase in early intervention services has come the need for appropriate assessment and curriculum methods and materials. The LAP meets the need for a method of systematic observation of children who are functioning at an early level of development. It is a criterion referenced instrument.

While this instrument can provide valuable information on normal child development, for parents of typical children, the Early LAP is intended for use with handicapped or developmentally delayed children who are functioning in the birth to 36 month range. This instrument is designed to facilitate appropriate programming by providing a developmental sequence in various skill areas. This systematic observation, commonly referred to as the assessment process, examines the child's skills in relation to a set of specified criteria. The Early LAP neither assigns a label nor makes assertions regarding the causes of behavior. Rather, it provides a system for recording the demonstration of a child's specific skills at a particular time, with a particular administrator.

The Early LAP provides intervention personnel with a systematic structure for observing the child's strengths and weaknesses which can be translated into specific developmental goals and objectives. This focus on specified behavior also enables program personnel and families to observe the child's developmental progress. The criterion referenced approach to assessment represents a significant departure from the traditional use of standardized testing devices which are designed to compare a child's performance with that of other children of the same age.

Typically, the norm referenced approach with its focus on the generation of global scores provides little specific information for structuring a developmentally appropriate curriculum for the individual child. The Early LAP was developed by sequencing a selection of specific learning tasks from 18 researchers of early childhood development. These items are categorized in six skill areas--gross motor, fine motor, cognitive, language, self help and social/emotional.

The language skill area is divided into two categories: receptive language and expressive language. Receptive items assess a sample of abilities in language comprehension. Expressive items assess some skills in oral language or speech. Many language tasks involve both receptive and expressive language skills. These items were analyzed and placed in the category which reflects the primary language skill involved. For the deaf, cerebral palsied, hearing impaired, and communicatively handicapped children, it is important to make accommodations in order not to penalize the child who has limited communication capability.

The Early LAP provides a section for summarizing the child's strengths and weaknesses in each skill area. This arrangement of information can be useful for discussion with the child's parents and can also provide an organizational structure for the preparation of the child's Individualized Educational Program or IEP. The IEP provides for annual goals, instructional objectives, criteria for on going assessment, special services and parental approval.

A new world of opportunity is dawning for handicapped children and their families. With the development of appropriate assessment instruments, the effectiveness of early intervention will be strengthened. The earlier intervention begins, the more successful it will be.

Dr. John Turner provided the symposium with information on the Integrated Social Service program in Egypt. The University of North Carolina provided assistance to Egypt to develop ways of improving the social service delivery system. These services include cash assistance programs, care of handicapped persons, and a variety of other programs. As an adjunct of this activity, the LAP and Chapel Hill Outreach materials were translated and adapted to the Egyptian culture.

The technical assistance team worked with the Ministry of Social Affairs to accomplish these goals:

. develop new programs

. make services more responsive to the needs of the people

. make the services more effective

. make the services more efficient

This involved training, administration and evaluation. It is important to note that the team worked with their Egyptian colleagues, not for them.

To develop new programs, to improve programs, to make them more responsive, to make them more effective and to make them more efficient involved changing the behavior of people. Ultimately the team was involved in trying to change the way the system operated. Children were simply one target group; they were not the only concern. However, one cannot do anything very long before realizing that children are a basic concern of the Egyptian population--there are many of them. Indeed, children play a very central role in Egyptian culture. The elderly and parents are also very important in Egyptian culture.

The government of Egypt through its Ministry of Social Affairs had invested a fair amount into early childhood care. They operated or financed over 2,000 centers for preschool children. This does not include the programs for handicapped children.

Day care or nursery programs are operated in multiple service center. A center is like a settlement house. The centers are decentralized, in small towns or in villages. They may be in villages that have five or six satellite villages around. Some centers had one room, others up to seven rooms. Enrollments ranged from 10 to 130 children. Each center had two or three women or young girls to teach and provide supervision for the children. Within those centers an observer could see much variation in the quality of activity and program. The children were being looked after. There was no physical neglect, but there was an absence of a child development purpose as a framework for a program.

The team's basic concern was the development of some type of program for the 2,000 centers throughout the country. Through the efforts of Anne Sanford and the First Lady of Egypt, Mrs. Sadat, an interest developed whereby the team investigated the possibility of integrating the Learning Assessment Profile into day care centers. The material had to be translated into Arabic and had to be adapted culturally.

While the translation and adaption of the LAP were being carried out, three questions were addressed:

- Is the material easily adaptable to this lifestyle?
- Is this a practical program?
- Are the parents aware of existing programs, and will they accept new programs?

These questions could be considered when adapting any materials from other cultures.

In the spring of 1981, eight Egyptian leaders visited the Chapel Hill project for two months of intensive training. The expenses for the Egyptian training/replication were financed by AID through the Egyptian integrated social service project. The Chapel Hill model is now forming the basis of services to young handicapped children in selected demonstration sites in Egypt.

DENMARK

Mr. I. Skov Jorgensen provided the symposium with the following information about personnel preparation and blending of medical, health care, education and social services in his country.

The starting point for personnel training is a political decision in most countries. The philosophies of integration vs. segregation are the major points in developing a plan for special education personnel training. In Denmark integration is wide spread and widely accepted, but the need to individualize and integrate classes challenges a normal teacher. Teachers are assisted by case workers from the Pedagogical Psychology Advisory Service who follow children with special needs as long as necessary. The case worker is supported by an interdisciplinary team which may include school psychologists, clinical pychologists, social workers and consultants knowledgeable about various handicapping conditions.

The basic teacher training curriculum uses the subjects of psychology, pedagogy, and the theory and practice of teaching to familiarize teachers with the needs and situations of handicapped children. The basic training program for all teachers includes a solid orientation in handicapping conditions and the problems they may present in a teaching situation.

To support active social intervention work in ordinary classes, all training college students may be taught the basic rules of special education by means of a 150 lesson course. In addition to a practical orientation to the various subject fields, the training college student must choose one of three pedagogical special subjects. One of these is special education. One half of the students choosing this subject must complete a course of 224 lessons; this qualifies them for special teaching. Teacher training with the education of handicapped children as a special subject and two years of practical experience allows a teacher to participate in specialized teacher training lasting one and a half years. During the first half year of this training, the special pedagogy is taught in general terms. The next semester is extremely specialized, with subjects chosen from the areas of speech handicap, visual handicap, hearing handicap, motor handicap, physical inhibition, multi-handicap and the socially and emotionally handicapped.

To qualify as staff for institutions of research and of training teachers, persons are required to study for two more years, and they have the opportunity for continuous scientific studies.

Whether or not severely handicapped school children are able to live at home depends on medical and social assistance as well as the availability of a suitable educational facility. Efforts are made to place facilities where a maximum number of children can travel back and forth to school daily. However, children for whom this travel is not possible go to Monday to Friday rooms.

Separate classes are set up in regular schools. In one school there may be classes for children with hearing handicaps, another may have classes for those with speech defects, and so on. Classes are established beside regular classes for the same age group. Special treatment, for example physiotherapy, occupational therapy and expertise on relevant handicaps, are also available in the schools. The responsibility for providing appropriate services rests with the local educational authorities as far as possible. However, most ministries and organizations are involved in increasing the integration of handicapped people in society. Many barriers have been broken during recent decades; still many remain to be broken.

The most essential aspect of the system might be that children grow up together in kindergarten and schools with a record of cooperation. It is a main philosophy for Denmark that authorities responsible for services for the general population are also responsible for corresponding services for the handicapped population.

A study in Denmark investigated parents' reactions after the birth of a handicapped child. The study showed that too many parents continue to be referred from one examiner to another, with little coordination among the examiners. Parents also felt that many professionals they meet in their search lack sufficient knowledge about their child's handicap. From this and other studies it could be concluded that a preventive, early investigation program should be guaranteed, that parents should be given accurate information about the nature of the child's handicap, that the information should be provided by an able person who has sufficient time to answer questions and to make sure that the answers are understood, and that the information includes a description of what can be done for the child immediately and what services are available now and later. The parents should be referred to a single individual who can act as their contact person in obtaining information and services, and who can offer help in solving a problem or working with a complex service system. Finally, some special education programs, especially those in early infancy, should be developed.

INDIA

Mr. Harcharan Jit Singh provided the symposium with the following information about medical care, health care, education and social services in his country.

In India, the problem of providing adequate services is gigantic. There are 650 million people; out of this group, 50 million are children. Any program that is started in India has to be based in the rural areas so as to reach the maximum number of persons.

The Integrated Child Development Services (ICDS) was started in 1975 as an experimental project in 33 provinces. At present it is in 200 provinces all over the country. The majority of the projects are in rural areas and the others are in tribal and urban slots. The priority in setting up a project was to reach underserved areas. By 1985, there should be 110 projects.

As the name suggests, the program endeavors to provide comprehensive services for children in an integrated manner. The services include supplementary nutrition, immunization against various diseases (especially polio), health and nutrition education to mothers, health check-ups and preschool education.

Supplementary nutrition is provided for children below six and for pregnant and nursing mothers. Special care is taken that all the children in the project are immunized against various diseases. They are especially concerned about polio vaccinations since 50 to 60 percent of ortheopedic handicaps among children in India is a result of polio. While they have not completed immunization among the children, their target is 85 percent of the child-population by 1990.

They also try to see that safe and clean drinking water is available wherever these projects are located. It was found that the effects of the supplementary foods given to children and pregnant mothers were not visible. It was discovered that safe drinking water was not available at some places; this counteracted any good effects of supplementary nutrition.

The aim of this program is to foster normal development of the children and to equip mothers to take better nutritional care of the children. It is assumed that given education, especially in health and nutrition, and dietary supplements, mothers can better care for their children and can provide them with better nutritional health.

To operate ICDS the country was divided into more than 5 thousand blocks, each block having an average of .1 million people. It is estimated that 16 to 17 percent of each block is inhabited by children and pregnant and nursing mothers.

Each block has one supervisor, known as the Child Development Project Officer. Under the supervision of this Child Development Project Officer there are one hundred workers, each responsible for a group of one thousand people. These workers are known as "anganwadi" workers. They have been given this name because they work in the courtyard of the villages. All of the children and mothers come to the courtyard; education and the supplementary nutrition are given in the courtyard. These one hundred anganwadi workers or courtyard workers are responsible for implementing the project.

The anganwadi worker is a married woman from the village she serves. Because the program caters primarily to women, and because of certain taboos and shyness, the services are more effective and more accepted when administered by a woman. It is important that the worker be married, because it means that she has moved into her husband's village and will stay; it is likely, therefore, that she will also stay in her job. To qualify as a worker, she must pass eight classes. Apart from providing nutrition for the children and education to the mothers, the anganwadi worker visits every house in her area at least once in 14 days. This was built into the program to take care of pregnant and nursing mothers and children who cannot come to that courtyard.

Each project is linked with a Primary Health Center. This Center has a baby health visitor and a community health worker to coordinate the health services. The Primary Health Center, the community health worker, the baby health visitor, and anganwadi worker work together to provide immunization and health check ups. Medical colleges are also involved with this project; interns must spend some time in the project before they are eligible for degrees.

Another aspect of this project is the community involvement. Usually, the Child Development Project Officer or the doctor from the medical college works with community leaders. Although community involvement has not been achieved in all projects, it has in some areas. For example, some communities have whole grain wheat or other things which can be used in the supplementary nutrition program. Ultimately it is given back to the children or the mothers from the same village.

Malnutrition and polio are the two major causes for handicapping conditions in India. These projects are aimed at giving supplementary nutrition and immunization to children, thus preventing disabilities. Sometime in the future, these projects will also have an additional worker who will be responsible for identifying and rehabilitating disabled children.

APPENDIX A

INTERNATIONAL SYMPOSIUM ON SERVICES FOR YOUNG DISABLED CHILDREN, THEIR PARENTS, AND FAMILIES

AGENDA

SUNDAY - December 6, 1981

Council Room

6:00 P.M. - Welcome
Adrienne McCollum, President
Research Assessment Management, Inc.

Orientation and Logistics
Joyce Martin Hickman, Symposium Coordinator
Research Assessment Management, Inc.

7:00 P.M. - Dinner

MONDAY - December 7, 1981

8:00-9:00 A.M. - Breakfast

9:00-10:00 A.M. - Welcome - Introductions
Presiding:
Jean Tufts, Assistant Secretary
Office of Special Education and Rehabilitative Services
U. S. Department of Education

Lena Saleh, UNESCO
Paris, France

Shirley Jones, Deputy Director
Special Education Programs
U. S. Department of Education

Cecilia Frantz, Director Designate
National Institute of Handicapped Researach
U. S. Department of Education

John H. Rodriguez, Deputy Under Secretary
Intergovernmental and Interagency Affairs
U. S. Department of Education

MONDAY - December 7, 1981 - Continued

10:00-10:15 A.M. - Break

10:15-12:00 Noon - Session I
Identification, Screening, Assessment and Evaluation of Young Children
Presiding:
Jane DeWeerd
Special Education Programs
U. S. Department of Education

12:00-1:30 P.M. - Lunch

1:30-3:00 P.M. - Session II
Programs for Children and Parents
Presiding:
Sandra Swift Parrino

3:00-3:15 P.M. - Break

3:15-5:00 P.M. - Session III
Portage Project
Presenter:
George Jesien

6:00-7:00 P.M. - Dinner

TUESDAY - December 8, 1981

7:30-8:30 A.M. - Breakfast

8:30-10:00 A.M. - Session I
Personnel Training
Presiding:
Naomi Karp
National Institute of Handicapped Research
U. S. Department of Education

10:00-10:15 A.M. - Break

10:15-12:00 Noon - Session II
Chapel Hill Outreach Program
Presenters:
Anne Sanford
John Turner

12:00-1:30 P.M. - Lunch

TUESDAY - December 8, 1981 - Continued

1:30 P.M.-2:45 P.M. - Session III
Blending Medical, Health Care, Education and Social Services
Presiding:
Sandra Swift Parrino

2:45-3:00 P.M. - Break

3:00-4:00 P.M. - Session III (continued)

5:30-6:30 P.M. - Dinner

8:00 P.M. - Handicapped Children's Early Education Program (HCEEP)
Conference and Hospitality
Sheraton Washington Hotel

WEDNESDAY - December 9, 1981

8:00-9:00 A.M. - Breakfast

9:00-12:00 Noon - Visit:
National Children's Center

12:00-1:00 P.M. - Lunch

1:00-3:00 P.M. - Visit:
The Training and Infant Intervention Program
Howard University

5:30-6:30 P.M. - Dinner

8:00 P.M. - HCEEP Conference
Sheraton Washington Hotel
Opening Speaker:
Bettye Caldwell

THURSDAY - December 10, 1981

8:00-9:00 A.M. - Breakfast
Executive House

9:00-12:00 Noon - HCEEP Conference
Sheraton Washington Hotel
(Choice of Sessions)

12:00-1:00 P.M. - Lunch

Sheraton Washington Hotel

THURSDAY - December 10, 1981 - Continued

1:00-5:00 P.M. - Work Session

6:00-7:00 P.M. - Dinner

FRIDAY - December 11, 1981

8:00-9:00 A.M. - Breakfast

9:00-9:30 A.M. - Greetings
Virginia Knauer
Special Assistant to the President of the United States

Harold O'Flaherty, Executive Director
International Year of Disabled Persons
Federal Secretariat for The Federal Interagency Committee
United States Government

9:30 A.M. - Wrap-up Session
Future Directions
Presiding:
Ruth-Ann Rasbold
Sandra Swift Parrino

12:00-1:00 P.M. - Lunch

2:00 P.M. - Ceremony and Reception
International Year of Disabled Persons
Hubert Humphrey Building

APPENDIX B

PROFILES OF CONFERENCE PARTICIPANTS

Cameroon

Sister Cecile Cusson
Catholic Mission
B. P. 97 Kaele
Cameroon

Sister Cecile received her formal training at Annhurst College, Woodstock, Connecticut and at the Cambridge, Massachusetts Nursing School.

She has spent twenty-seven years in Africa, teaching first aid skills to parents of polio victims, providing medical care of persons with tropical diseases, and providing bedside nursing to persons with chronic and incurable diseases.

Sister Cecile has written the first Mundang Book in the African dialect on improving health care.

Denmark

Mr. I. Skov Jorgensen
Ministry of Education
1552 Copenhagen V
Denmark

Mr. Jorgensen holds degrees in teacher training, sports and recreation, and psychology from Copenhagen University.

His professional career has included teaching and serving as school psychologist and as Superintendent of Special Education. He has been involved in international experiences with the World Conference of Teaching Professions (WCOTP), the Nordic Council and the United Nations Educational, Scientific and Cultural Organization (UNESCO). He holds memberships in the Denmark Teachers Association and the Association of School Psychologists.

Egypt

Dr. Mohyi El Din Ahmed Hussein
47 Shahab Street, Apt. 3
Pyramids Road
Giza, Egypt

Dr. Hussein holds a Ph.D. degree in Psychology from Cairo University and presently is a lecturer in Psychology at Cairo University. In addition he is a consulting clinical psychologist at Behman Mental Hospital.

He was a consultant to the University of North Carolina Technical Assistance Team in Egypt and translated the Chapel Hill Project materials into Arabic. His professional memberships include the British Psychological Society, the Egyptian Psychological Society and the Egyptian Behavior Therapy Society.

Ghana

Mr. David T-K Aryee
Deaf Education Specialist Training College
P. O. Box 33
Ghana, West Africa

Mr. Aryee has received formal training in education of the deaf at the University of Manchester and Cambridge University in England.

He has been a teacher at the post-secondary training school and at the University of Science and Technology, at Kumasi, Ghana.

He has conducted seminars on working with the deaf in Ghana, Kenya, and Japan.

In recognition of Mr. Aryee's work, he was honored by the state of Ghana with the award of the Grand Medal in 1975.

India

Mr. Harcharan Jit Singh
Under Secretary - Government of India
Ministry of Social Welfare
Shastri Bhawan
New Delhi, 110001
India

Mr. Singh received his education at Punjab University in Chandigarh, India. His professional responsibilities have involved coordinating, directing and formulating programs for International Year of Disabled Persons, implementation of Integrated Child Development Services, and implementation of a plan for day care of children of working or ailing mothers.

Mr. Singh has also been instrumental in an effort to promote the idea of voluntary help for handicapped people. He has assisted the government in formulating programs for education, training, and rehabilitation of handicapped people.

Jamaica

Mrs. Joyce Brown, Supervisor
Caribbean Institute on Mental Retardation and Developmental Disabilities
23 West Amour Heights
Box 447, K 8
Jamaica, West Indies

Mrs. Brown was educated in Hammersmith, London, Edinburg, Scotland, and Surrey, England, in the areas of nursing, obstetrics and public health.

She has been involved in nursing, especially in the area of early intervention with premature babies, has been a school nurse, and presently is involved in parent education as it affects developmentally disabled children.

Japan

Dr. Hideo Ogamo
Shukutoku University
Skyheights 413
Ohanajaya 3-24-25, Katsushika-Ku
Tokyo 124, Japan

Dr. Ogamo received his formal training at Tokyo University and Teachers College, Columbia University, New York. He has been a teacher, supervisor, superintendent and researcher in the area of special education. He holds memberships in the Japan Special Education Society and the Japan Council for International Year for Disabled Persons.

Mexico

Mrs. Isabel Farha Valenzuela
Assistant Director of Special Education
Ministry of Education
Camino Al Desierto #35
San Angel
Mexico 20, DF

Mrs. Farha received degrees in Special Education with special work in Speech and Hearing from the Model Oral Institute, Rosario University, Argentina and the Mexican Institute of Hearing and Speech in Mexico City.

Prior to becoming Assistant Director of Special Education with the Ministry of Education, Mrs. Farha was Pedagogical Director of the Mexican Institute of Hearing and Speech, Counselor in Research of adaptation of the Illinois Test of Psycholinguistic Abilities, and a university teacher in the career of hearing and speech speciality.

Her professional associations include the International Reading Association, School of Professionals in Special Education. She has also served as President of the Hispano American School of Hearing, Speech and Voice Problems.

Nigeria

Mrs. Ellen Caulcrick
Federal Ministry of Education
Special Education Section
Victoria Island
Lagos, P.M.B. 12573
Nigeria

Mrs. Caulcrick holds a degree in Teacher Training, Education of Maladjusted and Emotionally Disturbed Children from the University of London, a Masters degree in Social Work from Washington University, St. Louis, Missouri and a Certificate of Advanced Graduate Study from Boston University, Boston, Massachusetts.

Her professional career has included positions as classroom teacher in a Methodist Mission, headmistress of a senior girls' school, play therapist in the Child Guidance Center. She is currently working in Organization and Administration of Special Education Programs for the Federal Ministry of Education.

She is a member of the National Association for Handicapped Children, National Association for the Deaf, and the National Association for Mental Health.

Pakistan

Mr. Mike Miles
Mission Hospital
Peshawar, Pakistan

Mr. Miles received formal training at Bristol Polytechnic Institute and Leeds University, both in England.

He has worked in many capacities in England and Pakistan, and is currently an administrator and developer of rehabilitation facilities in the Non-Governmental Organizations of Pakistan. He serves as an unofficial advisor to the government of Pakistan and project consultant to UNICEF in rehabilitation development.

United Kingdom

Dr. Duncan Guthrie
c/o Institute of Child Health
Wildhanger
Amberley
Arundel
W. Sussex, BN18 9NR
England

Dr. Guthrie received formal education in England and has received honorary degrees from Glasgow University, Oxford University and Queen's University in Belfast, Ireland.

His professional career has been geared toward research and in assisting in disabled children. Positions he has held include Director of CHILD-to-child Programme, Director of the Disabilities Study Unit, and Director of the Central Council for the Disabled. He is also the Founder and Director of National Fund for Research into Crippling Diseases.

Dr. Guthrie is a member of the Bristol Orthopedic Association and is a Fellow of the Royal Society of Medicine.

United States

Mr. George Jesien
Portage Project
412 E. Slifer Street
Portage, Wisconsin 53901
U.S.A.

Mr. Jesien received the Bachelor's degree at LeMoyne College, Syracuse, New York, and a Master's degree in Educational Psychology from the University of Wisconsin.

He has been a teacher, special education coordinator, school psychologist, and presently is Co-Director for the El Proyecto Portage, a Specific Purpose Grant funded by the Agency for International Development to provide Technical Assistance in home-based early intervention methodology in Latin America.

Uruguay

Mrs. Eloisa Garcia de Lorenzo
InterAmerican Children's Institute
Montevideo, Uruguay

Mrs. Lorenzo received her formal education in Uruguay and at the University of Michigan in the areas of clinical psychology and special education. She served as an intern at the Cove School in Wisconsin and received credentials from the Department of Vocational Rehabilitation, U. S. Department of State.

Mrs. Lorenzo has been a teacher of special education and presently is chief of Special Education and Pre-School Section at the InterAmerican Children's Institute.

Additional Participants

Ms. Anne Sanford
Chapel Hill Outreach Project
Lincoln Center
Merritt Mill Road
Chapel Hill, North Carolina 27514

Dr. John Turner, Dean
University of North Carolina School of Social Work
Old Consolidated Building 150-A - Franklin Street
University of North Carolina
Chapel Hill, North Carolina 27514